RA-24 (Rev. 6/98)

Michigan Department of Career Development

REHABILITATION SERVICES

INFORMATION REQUEST

[For Office Use Only]
Counselor Name

Reset

1. I, _____, [_____], [_____],
   [Client's Name] *[Social Security Number]* *[Birthdate]*

   authorize the release of information from _____,
   [Hospital, Clinic, Agency, School or Individual]

   or its director, designee, or records department to:

This permission to release information includes any follow-up communication needed to carry out the purpose of disclosure.

2. Specific type(s) of information is to be disclosed:

   ☐ Medical and psychological records for physical and/or mental illness, including alcohol and drug abuse treatment information protected under the regulations in Title 42 of Federal Regulations Part II.
   ☐ Discharge Summary ☐ History and Physical ☐ Treatment Plan/Record
   ☐ Diagnosis ☐ Other [specify]: _____

   ☐ Information about Human Immunodeficiency Virus *(HIV)*, Acquired Immune Deficiency Syndrome *(AIDS)*, or other communicable and severe communicable diseases as defined by Public Act 174 of 1989.

   ☐ Academic, Vocational, and/or special Education Information

   ☐ Other *[specify]:* _____

3. The purpose(s) and need for such disclosure:

   ☐ Establish eligibility for vocational rehabilitation services
   ☐ Develop and carry out a vocational rehabilitation program for client
   ☐ Determine need for and/or type of treatment or accommodation
   ☐ Other [specify]: _____

4. I understand that in order to accomplish the above need for disclosure it may be necessary for Michigan Rehabilitation Services [MRS] to share my records with other parties involved in my rehabilitation program except when prohibited by law, including records pertaining to substance abuse which require my specific writtten consent to further divulge under 42 CFR, Part II. I understand this release of information includes release to the Client Assistance Program.

5. This consent may be revoked at any time. It shall be valid no longer than is reasonably necessary to accomplish the purpose for which it is given.

6. The consent expires upon the following condition(s) unless expressly revoked by me.

   Date: _____, or Event: _____

A copy of this file is needed for the client's records

Client's Signature	Date
Parent's or Legal Guardian's Signature, *if applicable*	Date
Witness' Signature	Date

NOTIFICATION OF POLICY REGARDING RELEASE OF INFORMATION TO CLIENTS

***In accordance with federal regulations (34 C.F.R. 361.38), Michigan Rehabilitation Services must make available to an individual all information in the individual's casefile with two exceptions*:**

1. ***Medical, psychological, or other information which may be harmful to the individual will not be provided through a representative designated in writing by the individual. Agency policy requires that the representative be a physician, psychologist, attorney, or other responsible person exclusive of parent, child, or spouse.***

2. ***Personal information obtained from another agency or organization will only be released under the conditions established by that agency or organization.***